Linda M Lawrence, M.D.
Ophthalmology
Surgery and Diseases of the Eye
1410 E Iron, Ste 6 Salina, Ks 67401
Phone: 785-823-1600 Fax: 785-823-8953

AUTHORIZATION FOR THE RELEASE AND/OR DISCUSSION OF PROTECTED HEALTH INFORMATION TO BE SENT TO DR. LINDA LAWRENCE

Patient Name:____DOB:_______________

I, _____________________________________ hereby authorize:
(patient or legally authorized representative)

____
(Name of doctor(s) from whom we are asking for their records)

Phone#______________________________ Fax#____________________________

to release and/or discuss the following information(circle complete or list specified info):

Complete Record or Specified Information Only Listed Below

____

____

To be sent to: Linda Lawrence, M.D. 1410 E Iron, Ste 6, Salina, Ks 67401
Fax: 785-823-8953

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun. This authorization expires one year from today's date.

Signature:____ Date:_________________

Relationship:____________________________